Dept. Health,
Educ., & Welfare
U. S. Public
Health Service

V. S. 300
Rev. 1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

43904
STATE FILE NUMBER

FILED DEC 24 1957 Registration District No. 96 Primary Registration District No. 5356 Registrar's No. 103

1. PLACE OF DEATH
a. COUNTY: DALLAS
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only): LONGLANE — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location):
Length of stay in 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY: Dallas
c. CITY OR TOWN: Long Lane — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location):
Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: FRANCIS Middle: MARION Last: LAWSON
4. DATE OF DEATH: Month 12 Day 8 Year 1957

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9-28-1875
9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Laclede Co Mo
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Acie Lawson
13b. MOTHER'S MAIDEN NAME: Juliana —
14. NAME OF HUSBAND OR WIFE: Alice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clarence Lawson — Address: Buffalo Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

	Cause	Interval between onset and death
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage (Apoplexy)	10 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arterio Sclerosis	10 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 331X

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1956, to 12-8-57 and last saw him alive on 12-7-57
Death occurred at ____ m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): C. O. Hammon. M.D.
22b. ADDRESS: Buffalo Mo
22c. DATE SIGNED: 12-14-57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 12-10 1957
23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn
23d. LOCATION (City, town, or county) (State): Buffalo Mo

24. FUNERAL DIRECTOR: L B Jones — ADDRESS: Buffalo Mo
25. DATE RECD. BY LOCAL REG.: 12/23/57
26. REGISTRAR'S SIGNATURE: Mrs Grace Petree by

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Leonard B Jones

Licensed Embalmer No. 2508

P. O. Address Bonfils Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.